Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STEVEN E NOLAN
7401 SOUTH MAIN
HOUSTON TX 77030

Respondent Name
HOUSTON ISD

Carrier's Austin Representative
Box Number 21

MFDR Tracking Number
M4-11-0904-01

MFDR Date Received
November 15, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received your payment on the claim for the above date of service. We are disagreeing with your decision for the fact that it was not based on the correct contract, all surgery claims should be process [sic] @174% of the current fee schedule when using Rockport as the PPO network."

Amount in Dispute: $926.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached please find a copy of the EOB and a copy of the check showing an additional payment of $319.59 for arthroscopic knee surgery since the original response. As requested please also find attached a copy of the contract between Rockport and Fondren Orthopedic Group, LLP."

Response Submitted by: Thornton, Biechlin, Segrato, Reynolds & Guerra, L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2009	G0289, 29876 and 29881	$926.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- W1 – Workers Compensation State Fee Schedule Adjustment
- 59 – Processed based on multiple or concurrent procedure rules.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. $0.00
- W3 – Additional payment made on appeal/reconsideration

Issue

Did the requestor waive the right to medical fee dispute resolution?

Findings

Per 28 Texas Administrative Code §133.307(c) (1), "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

The date of the services in dispute is October 5, 2009. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on November 15, 2010. This date is later than one year after the date(s) of service in dispute.

Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 24, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.